

APPENDIX B

EFFECTS OF SELECTED FEE SCHEDULE OPTIONS

This appendix presents estimates of the effects on physicians and their Medicare patients of specific options for setting payment rates under a Medicare fee schedule. Of the many combinations of features that could be analyzed, only a small set of illustrative options is presented.

Two fundamental decisions must be made if a fee schedule is to be implemented:

- o What physician specialty groups to differentiate and how to define the relative value scale (RVS) for each;
- o What geographic areas to identify for rate differentials and how to set the differentials.

The implications of alternative choices for defining differentials by specialty and location are examined in the second and third sections of this appendix, following a discussion of the data base used for the analysis.

THE DATA BASE AND ITS LIMITATIONS

The data used by the Congressional Budget Office for its simulations are Medicare claims submitted for a one-percent sample of physician practices in 41 carrier jurisdictions for calendar year 1984. The fee ceilings or fee schedule rates used for the simulations were based on average submitted charges for all Medicare claims made in the 41 jurisdictions for 1984.¹ Thus, the relative value scale (RVS) implicit in the fee schedules examined

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1. These rates were calculated from the Health Care Financing Administration's 1984 Part B Medicare Annual Data Procedure file, which contains charge information for all services billed to Medicare. Although rates could, in principle, be based on average allowed amounts instead, this was not done because reporting errors made the calculation of the number of times a given service was paid for by Medicare suspect for nearly 95 percent of the charges recorded on the procedure file.

here replicates the current structure of submitted charges by physicians, which many analysts believe should be modified. The effects obtained reflect the results of eliminating the large variation among physicians in payment for the same service, but incorporate little modification in average payments for some services relative to others.

Fifteen of the 56 Medicare carriers were eliminated from the analysis because of various problems in reporting the data. The remaining 41 carriers processed claims representing about two-thirds of Medicare's allowed amounts for 1984. Overall, counties in the carrier jurisdictions that were used were very similar to the national average in the proportion that were urban, in wage levels (as measured by the PPS wage index), in poverty rates, and in per capita income. By census region, however, the jurisdictions excluded in the East were more urban, and those excluded in the other census regions were less urban, than those included in the analysis (see Table B-1).

Claims for the services of radiologists, anesthesiologists, and pathologists were eliminated because of difficulties in establishing appropriate payment rates for these specialties for 1984.^{2/} Claims by pediatricians, psychiatrists, and osteopathic physicians were also eliminated because so few services were provided to Medicare enrollees by these groups. For the specialty groups included in the analysis, the distribution of Medicare's allowed amounts in the sample was similar to the distribution by specialty of all allowed amounts for 1984 (see Table B-2).

To reduce computation costs, only the top 258 services (ranked by total allowed amounts in 1984) were used for the analysis. These services accounted for about 70 percent of all charges approved by Medicare for the physicians in the sample, although this varied by specialty group.^{3/} The 258

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2. Before October 1, 1983, the patient-related services of radiologists and pathologists were often billed by hospitals instead of physicians (a practice known as combined billing). Hospitals' allocation between the patient-related and administrative services of these physicians was sometimes arbitrary. As a result, when combined billing was eliminated in 1983, the customary fee profiles recorded by carriers and used for payment in 1984 for these physicians may not have been representative of appropriate charges for their services. The services of anesthesiologists are not reported in a consistent manner by carriers and the information reported is therefore difficult to use.
 3. These services accounted for 80 percent of approved charges, before eliminating claims for which the service codes in HCFA's Common Procedure Coding System (HCPCS) had modifiers attached. (Carriers use modifiers to indicate a range of special circumstances associated with the claim.) Only allowed claims for services reported without modifiers were used, in an effort to ensure that a homogeneous set of services was described by a given HCPCS code.

TABLE B-1. COMPARISON OF COUNTIES IN CARRIERS' JURISDICTIONS TO NATIONAL AVERAGES, BY CENSUS REGION

	Percent of Counties That Are Urban <u>a/</u>	Average Wage Index <u>b/</u>	Average Poverty Rate <u>c/</u>	Average Per Capita Income <u>d/</u>
All Carriers	23.6	1.00	13.5	9,049
Northeast	56.7	1.11	10.3	10,180
North Central	18.5	1.01	11.0	9,564
West	18.7	1.13	11.6	9,511
South	23.8	0.94	16.5	8,344
Carriers Included	25.6	1.02	13.5	9,069
Northeast	49.7	1.08	10.2	9,706
North Central	22.0	1.05	10.5	9,758
West	21.8	1.15	11.6	9,766
South	24.9	0.94	17.5	8,102
Carriers Excluded	19.8	0.97	13.4	9,011
Northeast	89.5	1.25	10.7	12,417
North Central	12.4	1.00	11.9	9,227
West	7.0	1.04	11.4	8,527
South	22.2	0.92	15.0	8,705

SOURCE: Congressional Budget Office tabulations from the Health Resources and Services Administration's May 1985 Area Resources file.

- a. Urban counties are those that are part of a metropolitan statistical area.
- b. The prospective payment system (PPS) wage index, based on hospital survey data.
- c. For 1980.
- d. For 1982, in dollars.

TABLE B-2. PERCENT DISTRIBUTION OF MEDICARE'S ALLOWED AMOUNTS BY SPECIALTY, NATIONWIDE AND FOR A ONE-PERCENT SAMPLE OF PROVIDERS, 1984

Specialty	Percent Distribution of Allowed Amounts		
	Nationwide for All Services <u>a/</u>	In the Sample for All Services <u>b/</u>	In the Sample for 258 Services <u>b/</u>
Generalists			
General practice	7.9	7.8	8.2
Family practice	5.0	5.0	5.9
Internal medicine	23.8	20.8	24.8
Nonsurgical Specialists			
Allergy	0.6	0.6	0.2
Cardiology	7.6	7.0	7.7
Dermatology	1.7	2.5	1.6
Gastroenterology	2.0	1.7	2.0
Nephrology	1.2	0.8	0.5
Neurology	1.7	1.4	1.5
Physical medicine	0.4	0.1	0.2
Pulmonary disease	1.5	1.2	1.3
Surgical Specialists			
General surgery	11.2	10.2	9.3
Otolaryngology	1.4	1.3	0.7
Neurosurgery	1.5	1.6	1.1
Gynecology	1.0	2.2	2.4
Ophthalmology	14.4	17.2	17.5
Orthopedic surgery	7.0	8.9	7.2
Plastic surgery	0.6	0.8	0.4
Colon and rectal surgery	0.2	0.2	0.2
Thoracic surgery	4.6	4.8	3.6
Urology	4.6	3.9	3.5

SOURCE: Congressional Budget Office.

- a. Tabulations from the Health Care Financing Administration's 1984 Part B Medicare Annual Data Procedure file.
- b. Tabulations from the Health Care Financing Administration's 1984 Part B Medicare Annual Data Provider file.

services accounted for 80 percent of all Medicare charges for generalists, 68 percent for nonsurgical specialists, and 62 percent for surgical specialists. Since all effects are presented as percent changes from current amounts, this variation by specialty in the proportion of total allowed amounts accounted for by the 258 services should not distort the results so long as the services used are representative for each specialty. Summary information about the data base is shown in Table B-3.

The national claims data base used here permits some advance over previous studies of physicians' fees, which had to rely on analysis of claims data from single carriers. Because of the broad national representation in the data base, the simulated effects of specific payment changes under Medicare by physician specialty and by urban/rural location are more likely to be an accurate representation of what would happen, on average nationwide, from Medicare policy changes. Because of the exclusion of several large carriers, however, the simulated effects on physicians by region are misleading. Consequently, effects are not reported by region.

Using a national data base that combines claims records from different Medicare carriers has some disadvantages. Because there may be systematic differences among the carriers in how claims information is recorded, simulation results may in some cases be misleading. For example, in most carrier regions, physicians did not report their services for 1984 using HCFA's Common Procedure Coding System; instead, carriers translated the services reported using other coding systems into HCPCS. It is uncertain how consistent the translations were from one carrier to another. In addition, even if services were reported in HCPCS, physicians differ in how they code given services--especially for visits, which are poorly defined.

The simulations are static, in that they assume unchanged behavior by physicians and their patients. The results are indicative of the initial financial effects of the alternative options, which might then be modified by the responses of physicians and their patients--such as changes in assignment or in use of services.

The simulations focus on the effects on the practice receipts of physicians--either Medicare's approved charges, payments by or on behalf of all Medicare patients (which would include balance-billing on unassigned claims), or payments by or on behalf of all patients including those who are not Medicare enrollees. Because the simulations are obtained from a sample of providers, not enrollees, it is possible to assess the impact on total practice income derived from Medicare patients but not the impact on patients' total liabilities for copayments and balance-billing. The impact on

TABLE B-3. PHYSICIANS' PRACTICE RECEIPTS AND PATIENTS' LIABILITIES, 1984 (In dollars)

Physician Practices by Specialty and Location	Number of Practices in the Sample	Current Receipts Per Practice			Patients' Liabilities Per Service <u>d/</u>
		Medicare Allowed Amounts <u>a/</u>	Revenue from Medicare Patients <u>b/</u>	Revenue from all Patients <u>c/</u>	
All Practices <u>e/</u>	1,952	32,164	36,403	105,812	15
Generalists					
General practice	348	14,816	17,111	54,821	10
Family practice	192	19,384	22,130	84,376	10
Internal medicine	398	39,099	44,981	90,417	11
Specialists					
Nonsurgical <u>f/</u>	250	37,885	41,873	143,138	16
Surgical <u>g/</u>	764	37,792	42,519	130,230	27
All Practices by Location					
Nonmetropolitan	283	27,892	32,637	92,205	10
Metropolitan	1,669	32,888	37,042	108,119	16

SOURCE: Congressional Budget Office tabulations from the Health Care Financing Administration's 1984 Part B Medicare Annual Data Provider file.

- a. Medicare's reimbursements are 74 percent of allowed amounts, on average. Reimbursements reported on the 1984 Medicare Annual Data files are not reliable.
- b. Medicare's allowed amounts on assigned claims; billed amounts on unassigned claims. This assumes that patients pay their share in full.
- c. Estimates, based on average Medicare reimbursements as a share of average practice income, by specialty. This is income per practice (as identified by Medicare carriers), not per physician. A practice may include more than one physician, and physicians may receive income from more than one practice.
- d. Average patient out-of-pocket expenses per service rendered, including deductible amounts, coinsurance on allowed amounts, and balance-billing.
- e. Includes claims submitted for the 258 top-ranked services (based on total allowed amounts in 1984) for all physicians in the sample except pediatricians, psychiatrists, osteopaths, radiologists, anesthesiologists, and pathologists. Data from 15 of the 56 Medicare carriers were excluded because of various reporting problems. The excluded carriers were for Georgia, Iowa, Michigan, eastern Missouri, Montana, New Jersey, eastern New York (the New York City area), North and South Carolina, North and South Dakota, Texas, Utah, Puerto Rico, and the Virgin Islands.
- f. Includes allergy, cardiology, dermatology, gastroenterology, nephrology, neurology, physical medicine, and pulmonary disease.
- g. Includes general surgery, otolaryngology, neurosurgery, gynecology, ophthalmology, orthopedic surgery, plastic surgery, colon and rectal surgery, thoracic surgery, and urology.

practice income from all patients is an estimate of average impact by specialty (not by practice), which is only partially derived from the simulations. ^{4/}

Although information is presented about the impact of each option on Medicare patients' liabilities per service, these effects are discussed only in the concluding section. Patients' liabilities include the deductible amount, coinsurance on approved charges, and balance-billing on unassigned claims. The simulations assume that all patient liabilities are paid in full.

The simulated results may understate the impact on receipts from Medicare patients and on receipts from all patients--and probably overstate the impact on patients' liabilities--because assignment rates reported in the 1984 data are below those currently reported for physicians' services to Medicare enrollees. (Charge-based assignment rates for physicians' services are currently above 60 percent, but are only about 52 percent in the data used for this study.) There are two reasons for the relatively low assignment rates in the data. First, whether assignment was accepted was not reported for about 11 percent of approved charges in the data: all of these charges were treated as unassigned claims, although some of them were probably assigned. Second, assignment rates have increased sharply since 1984, as discussed in Chapter II.

All of the options examined in this appendix are designed to be budget-neutral nationwide; that is, aggregate Medicare costs nationwide would be unchanged by the new payment rates, although the distribution of payments across physicians would change. Budget-neutrality nationwide was imposed for analytical reasons, so that the effects of changing the structure of payment rates could be seen in isolation, without the added complication of a change in total payment amounts. All options, however, could as easily be examined in the context of an increase or a decrease in aggregate Medicare payments.

SPECIALTY DIFFERENTIALS

A fee schedule might permit no differentials by specialty, paying the same amount for a given service to all physicians, or it might permit differentials

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4. Estimates for revenue from all patients were obtained using average Medicare reimbursements as a share of practice income, by specialty, reported by Arthur Owens, "How Much of Your Money Comes from Third Parties?" *Medical Economics* (April 4, 1983), pp. 254-263.

by specialty for some or all services. Seven specialty groups were used for those alternatives that would permit specialty differentials (see Table B-4). The seven groups were defined by the number of years of graduate medical education required to be board-eligible, with one exception. By the education requirement, family practitioners and internists would be in the same group, since both require three years of graduate medical education. These physicians were put in separate groups, though, because of the more general nature of the family practitioner's specialty training, which involves a mix of internal medicine, pediatrics, and other specialties.^{5/} If a fee schedule with specialty differentials were implemented, however, the definition of specialty groups and the differentials for each might depend not only on training time, but also on such factors as whether certain specialties were in over- or undersupply and what differentials had been paid historically.

In this section, four options for setting specialty differentials are examined, including:

- o A full fee schedule with no specialty differentials;
- o A full fee schedule with specialty-specific relative value scales;
- o A full fee schedule with specialty-specific multipliers; and
- o A partial fee schedule, for procedures only, with customary, prevailing, and reasonable (CPR) rates for visits and consultations.

The carriers' designation of specialty, which is generally the result of self-designation by physicians, was used. As discussed in Chapter IV, nearly half of physicians claiming a specialty are not certified in that specialty. Far more physicians who currently bill as specialists would be adversely affected under the options that allow specialty differentials if all physicians without board-certification in their specialty were paid the same rates as general practitioners. This alternative could not be analyzed, however, because the data used here do not indicate whether physicians are board-certified or not.

5. Although some of the specialties in the two groups requiring four and five years of graduate medical education face very different malpractice risks--depending largely on whether the specialty is a surgical one or not--these costs are more appropriately recognized in payment rates for specific services, rather than in higher payment rates for all services provided by surgical specialties.

TABLE B-4. PHYSICIAN SPECIALTY GROUPS

Grouping	Requirements for Board-Eligibility
General Practice	No board-certification available. States require one or two years of residency training to practice.
Family Practice	Three years graduate medical education in a mix of specialties.
General Internal Medicine	Three years graduate medical education in internal medicine.
Dermatology Neurology Physical Medicine Otolaryngology Gynecology Ophthalmology	Four years graduate medical education in specialty selected.
Allergy Cardiovascular Disease Gastroenterology Pulmonary Disease Nephrology General Surgery Orthopedic Surgery Plastic Surgery Urology	Five years graduate medical education in specialty selected.
Neurosurgery Colon and Rectal Surgery	Six years graduate medical education in specialty selected.
Thoracic Surgery	Seven years graduate medical education in specialty selected.

SOURCE: Congressional Budget Office using information in American Board of Medical Specialties, *Annual Report and Reference Handbook, 1984* (Evanston, Illinois: ABMS).

For all of the options, location-specific multipliers were selected such that aggregate Medicare payments to each state would be unchanged under the fee schedule from current amounts allowed under the CPR system; that is, the fee schedules examined in this section were designed to be budget-neutral for each state, as well as nationwide, to facilitate comparison with previous studies, all of which obtained results for fee schedules that were budget-neutral in the individual states they examined (California, Washington, and South Carolina). 6/

Statewide Fee Schedules With No Specialty Differentials

A statewide fee schedule with no specialty differentials is the only alternative that has been examined in previous studies. Those studies used average allowed amounts to define the relative value scale, however, while average billed amounts are used here. (An RVS based on average allowed amounts could not be reliably calculated, as explained in footnote 1.)

The results obtained here by specialty are generally consistent with those obtained previously. Average receipts for generalists would increase at the expense of surgical specialists (see Table B-5). Even though generalists would gain substantially on average, about 10 percent of general and family practitioners would lose 10 percent or more in allowed amounts under this option, and nearly 30 percent of internists would be so affected. 7/

Allowed amounts would increase by an average of 13 percent for general and family practitioners, but would fall by nearly 5 percent for surgical specialists. The effects on physicians' revenues from Medicare patients would generally be smaller, because physicians' revenues from unassigned claims would not be affected by changes in Medicare's payment rates. Revenues from all patients would change by less than 2 percent, on average, because Medicare patients account for only a small portion (less than 20 percent) of physicians' gross receipts.

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6. See Chapter V and the Appendix in David Juba, "Analysis of Issues Relating to Implementing a Medicare Fee Schedule," Report No. 3481-01 (Urban Institute, Washington, D.C., November 1985), for a summary of previous results.
 7. Tables B-5 through B-12 show the unweighted percentages of practices that would gain or lose 10 percent or more in Medicare's allowed amounts. Results were also obtained for practices weighted by allowed amounts for each practice, with similar findings.

TABLE B-5. STATEWIDE FEE SCHEDULES WITH NO SPECIALTY DIFFERENTIALS, BUDGET-NEUTRAL BY STATE

Physician Practices by Specialty and Location	Percent Change In				Percent of Practices for Which Medicare Allowed Amounts Would		
	Medicare Allowed Amounts	Revenue from Medicare Patients	Revenue from All Patients	Liabilities Per Service	Increase by 10 Percent or More	Change by Less Than 10 Percent	Fall by 10 Percent or More
All Practices <u>a/</u>	0.0	0.0	0.0	-0.1	33.7	41.6	24.7
Generalists							
General practice	13.4	5.5	1.7	-5.7	53.0	36.9	10.1
Family practice	12.8	6.3	1.7	-3.9	52.1	37.5	10.4
Internal medicine	1.2	1.0	0.5	0.2	25.4	44.7	29.9
Specialists							
Nonsurgical <u>b/</u>	-0.4	0.9	0.3	2.2	30.8	40.0	29.2
Surgical <u>c/</u>	-4.6	-2.8	-0.9	0.8	25.5	43.8	30.7
All Practices by Location							
Nonmetropolitan	9.2	5.1	1.8	0.4	46.6	36.0	17.3
Metropolitan	-1.3	-0.8	-0.3	-0.2	31.5	42.6	25.9

SOURCE: Congressional Budget Office simulations from the Health Care Financing Administration's 1984 Part B Medicare Annual Data Provider file.

- a. Includes claims submitted for the 258 top-ranked services (based on total allowed amounts) for all physicians in the sample except pediatricians, psychiatrists, osteopaths, radiologists, anesthesiologists, and pathologists. Data from 15 of the 56 Medicare carriers were excluded because of various reporting problems. The excluded carriers were for Georgia, Iowa, Michigan, eastern Missouri, Montana, New Jersey, eastern New York (the New York City area), North and South Carolina, North and South Dakota, Texas, Utah, Puerto Rico, and the Virgin Islands.
- b. Includes allergy, cardiology, dermatology, gastroenterology, nephrology, neurology, physical medicine, and pulmonary disease.
- c. Includes general surgery, otolaryngology, neurosurgery, gynecology, ophthalmology, orthopedic surgery, plastic surgery, colon and rectal surgery, thoracic surgery, and urology.

One way in which the results of CBO's simulations differ from those reported in previous studies is that internists would gain along with general and family practitioners, although to a lesser extent. Previous studies indicated that allowed amounts for internists would fall by about half as much (in percents) as general and family practitioners would gain. For example, CBO's analysis of claims data for Washington state indicated that, if a statewide fee schedule based on average allowed amounts were implemented, internists' allowed amounts would fall by 3.8 percent while allowed amounts for general and family practitioners would increase by between 6.4 percent and 6.8 percent. Internists would fare better under a fee schedule based on billed amounts because they would be paid relatively more for hospital visits (a large component of their service mix) than under a fee schedule based on average allowed amounts.

General and family practitioners would likely be paid more per hour than more highly trained specialists under this option, though. A nationwide survey of medical practices conducted from 1975 through 1977 found significant differences by specialty in the time physicians spent with patients during visits.^{8/} On average, general practitioners spent only three-quarters of the time spent by internists during a "limited" office visit, for example. If this remains true, paying the same fee to all physicians for a given type of visit would result in a higher rate of pay (per unit of time) for general practitioners than for internists and other specialists.^{9/} If the HCPCS visit codes were redefined to reflect time, gains for general and family practitioners under a fee schedule with no specialty differentials would likely be substantially lower than those shown here, and gains for internists would likely be larger.

Statewide Fee Schedules With Specialty Differentials for Some Services

Specialty differentials could be obtained in either of two ways: by defining a separate relative value scale for each specialty group (based here on average billed amounts nationwide by physicians in that group); or by

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8. Robert C. Mendenhall, *Medical Practice in the United States* (Princeton, New Jersey: Robert Wood Johnson Foundation, 1981).
 9. In fact, general practitioners might currently be paid more per hour. Average allowed amounts nationwide for limited office visits by general practitioners are about 85 percent of average amounts allowed to internists for the same type of visit. If visits with general practitioners are still only about 75 percent as long as those with internists, then general practitioners are receiving a higher rate of pay per unit of time.

applying specialty-specific multipliers to a relative value scale that was uniform across all specialties, where the multipliers could be designed to reflect each specialty's training costs, for example. The first method--defining charge-based specialty-specific relative value scales--might better allow for systematic differences by specialty in how service codes are used, but would base all specialty differentials on current charge patterns whether or not they were justified. The second method--applying specialty-specific multipliers to a single relative value scale--might be an appropriate method if all services were well defined and coded consistently by physicians. Visits are poorly defined in HCPCS, however, and, as discussed above, there may be significant differences among physicians in how each visit code is used. Further, specialty-specific multipliers based only on graduate medical education would not take account of shortages or excess supply for some specialties.

Both of these alternatives are examined here, along with a third alternative that would retain CPR payment rates for visits and consultations (pending coding changes) while introducing a fee schedule for procedures.

Specialty-Specific Relative Value Scales. Results were obtained for two variants of this option--one that would permit specialty differentials only for visits and consultations, and one that would permit differentials for all services including procedures (see Table B-6). Although results for options that would permit specialty differentials are quite different from the alternative with no specialty differentials, the two variants discussed in this section are very similar. This is because only one or two specialties typically account for most of the claims for a given kind of procedure, so that payment rates for procedures are effectively already specialty-specific under the CPR system.

If specialty differentials were paid for visits and consultations based on each specialty group's billed amounts, the average increase in receipts for general practitioners would be smaller than if no differentials were paid, and the losses for surgical specialists would also be smaller. The increase in allowed amounts, for example, would be 4.1 percent for general practitioners under this option, compared with 13.4 percent under the option with no specialty differentials (see Table B-5). The average decrease in allowed amounts for surgical specialists would be 3.3 percent under this option, compared with a decrease of 4.6 percent if no specialty differentials were paid. Internists, on the other hand, would experience bigger gains in receipts under this option than under one without specialty differentials, because their fees for visits would not be reduced to the lower average that would result from including fees charged by general and family practitioners.

TABLE B-6. STATEWIDE FEE SCHEDULES WITH SPECIALTY-SPECIFIC RELATIVE VALUE SCALES, BUDGET-NEUTRAL BY STATE

Physician Practices by Specialty and Location	Percent Change In				Percent of Practices for Which Medicare Allowed Amounts Would		
	Medicare Allowed Amounts	Revenue from Medicare Patients	Revenue from All Patients	Patients' Liabilities Per Service	Increase by 10 Percent or More	Change by Less Than 10 Percent	Fall by 10 Percent or More
Specialty Differentials for Visits and Consultations; No Differentials for Procedures							
All Practices <u>a/</u>	0.0	-0.2	-0.1	-0.8	30.2	43.8	26.0
Generalists							
General practice	4.1	1.5	0.5	-1.5	38.0	40.3	21.6
Family practice	-2.9	-1.2	-0.3	-0.1	24.0	45.8	30.2
Internal medicine	5.3	2.4	1.2	-2.9	31.2	48.2	20.6
Specialists							
Nonsurgical <u>b/</u>	0.3	1.3	0.4	1.3	30.8	38.4	30.8
Surgical <u>c/</u>	-3.3	-2.2	-0.7	-0.2	27.6	44.2	28.2
All Practices by Location							
Nonmetropolitan	7.3	4.0	1.4	1.6	36.7	44.9	18.4
Metropolitan	-1.1	-0.8	-0.3	-1.1	29.1	43.6	27.3
Specialty Differentials for All Services							
All Practices <u>a/</u>	0.0	-0.1	0.0	-0.8	30.4	43.5	26.1
Generalists							
General practice	3.2	1.1	0.4	-1.2	36.3	40.3	23.3
Family practice	-3.6	-1.5	-0.4	0.4	24.0	45.8	30.2
Internal medicine	4.4	1.9	1.0	-2.5	29.6	49.0	21.4
Specialists							
Nonsurgical <u>b/</u>	2.2	2.6	0.8	1.8	33.6	38.0	28.4
Surgical <u>c/</u>	-3.2	-2.1	-0.7	-0.7	28.6	43.3	28.1
All Practices by Location							
Nonmetropolitan	7.0	4.0	1.4	1.7	36.4	45.6	18.0
Metropolitan	-1.0	-0.7	-0.2	-1.1	29.4	43.1	27.5

SOURCE: Congressional Budget Office simulations from the Health Care Financing Administration's 1984 Part B Medicare Annual Data Provider file.

- Includes claims submitted for the 258 top-ranked services (based on total allowed amounts) for all physicians in the sample except pediatricians, psychiatrists, osteopaths, radiologists, anesthesiologists, and pathologists. Data from 15 of the 56 Medicare carriers were excluded because of various reporting problems. The excluded carriers were for Georgia, Iowa, Michigan, eastern Missouri, Montana, New Jersey, eastern New York (the New York City area), North and South Carolina, North and South Dakota, Texas, Utah, Puerto Rico, and the Virgin Islands.
- Includes allergy, cardiology, dermatology, gastroenterology, nephrology, neurology, physical medicine, and pulmonary disease.
- Includes general surgery, otolaryngology, neurosurgery, gynecology, ophthalmology, orthopedic surgery, plastic surgery, colon and rectal surgery, thoracic surgery, and urology.

Family practitioners would lose under this alternative, providing another example of an instance in which the choice between using billed amounts or allowed amounts to define the RVS significantly alters the results. Using allowed instead of billed amounts to define specialty-specific fee schedules would be more favorable to family practitioners, because Medicare's allowed amounts are typically a higher proportion of billed amounts for family practitioners than for other specialty groups.^{10/} Using specialty-specific multipliers applied to a single RVS would also be more favorable to family practitioners than would this alternative, so long as the multipliers were directly related to years of graduate medical education, because family practitioners' payment rates would then be the same as those paid to internists (see the next section).

Specialty-Specific Multipliers. The specialty-specific multipliers used here were designed to compensate physicians with specialty training for the costs of their extra years of medical education compared with general practitioners, who enter practice with no further education beyond one or two years of residency training.^{11/} The multipliers were applied to a single relative value scale based on average billed amounts for all physicians, but only for visits and consultations. No specialty differentials were permitted for procedures. Since current charges for procedures are used to define the relative value scale, the additional training costs of the specialties most likely to perform specific procedures are probably already incorporated to a large extent. Applying specialty-specific multipliers as well would therefore doubly compensate specialists for their training.

This option would differ from the alternative that would permit no specialty differentials primarily in the treatment of general practitioners and nonsurgical specialists (see Table B-7). General practitioners would fare

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10. Family practitioners are classified as specialists, rather than as general practitioners, in many carrier jurisdictions. Consequently, the payment rate ceilings they face are higher than for general practitioners, while billed amounts are often similar for family and general practitioners.
 11. A multiplier was calculated for each specialty group that would, if applied to the visit rates paid to general practitioners, increase the discounted earnings stream of each specialty group by just enough to compensate them for the estimated costs of their additional education. Consequently, the discounted value of the expected earnings stream for each specialty group would be identical to that expected for general practitioners, making medical students financially indifferent between going on for specialty training or not. Average stipends paid to residents in specialty training were obtained for 1983 from the Association of American Medical Colleges. Starting income for general practitioners for 1983 was obtained from the American Medical Association. A 3 percent real rate of discount was assumed.

TABLE B-7. STATEWIDE FEE SCHEDULES WITH SPECIALTY-SPECIFIC MULTIPLIERS, BUDGET-NEUTRAL BY STATE

Physician Practices by Specialty and Location	Percent Change In				Percent of Practices for Which Medicare Allowed Amounts Would		
	Medicare Allowed Amounts	Revenue		Liabil- ities Per Service	Increase by 10 Percent or More	Change by Less Than 10 Percent	Fall by 10 Percent or More
		from Medicare Patients	from All Patients				
Specialty Differentials for Visits and Consultations; No Differentials for Procedures							
All Practices <u>a/</u>	0.0	0.1	0.0	0.3	36.1	39.9	24.0
Generalists							
General practice	7.9	3.1	1.0	-3.3	45.5	38.0	16.4
Family practice	13.5	6.7	1.8	-3.8	53.6	35.9	10.4
Internal medicine	1.2	0.9	0.5	-0.1	27.1	44.5	28.4
Specialists							
Nonsurgical <u>b/</u>	3.5	3.5	1.0	1.7	39.6	36.8	23.6
Surgical <u>c/</u>	-5.0	-2.9	-0.9	1.5	31.0	40.3	28.8
All Practices by Location							
Nonmetropolitan	8.7	4.9	1.7	1.1	45.9	36.4	17.7
Metropolitan	-1.3	-0.6	-0.2	0.2	34.5	40.4	25.1

SOURCE: Congressional Budget Office simulations from the Health Care Financing Administration's 1984 Part B Medicare Annual Data Provider file.

- a. Includes claims submitted for the 258 top-ranked services (based on total allowed amounts) for all physicians in the sample except pediatricians, psychiatrists, osteopaths, radiologists, anesthesiologists, and pathologists. Data from 15 of the 56 Medicare carriers were excluded because of various reporting problems. The excluded carriers were for Georgia, Iowa, Michigan, eastern Missouri, Montana, New Jersey, eastern New York (the New York City area), North and South Carolina, North and South Dakota, Texas, Utah, Puerto Rico, and the Virgin Islands.
- b. Includes allergy, cardiology, dermatology, gastroenterology, nephrology, neurology, physical medicine, and pulmonary disease.
- c. Includes general surgery, otolaryngology, neurosurgery, gynecology, ophthalmology, orthopedic surgery, plastic surgery, colon and rectal surgery, thoracic surgery, and urology.

less well under this option than under one with no specialty differentials because they would be paid lower rates for visits and consultations, reflecting the absence of specialty training. Nonsurgical specialists would do better under this option because they would be paid above-average rates for visits, based on the costs of their additional medical education.

Unlike the option with no specialty differentials, this alternative would recognize that the services provided by specialists during a visit of a given type may be more skilled than those provided by general practitioners. It would not allow for differences among physicians in how the visit codes are used, though. Consequently, family practitioners might be paid more per hour under this option than internists--although their additional training costs are the same--because visits of a given type tend to be shorter with family practitioners than with internists.

Partial Fee Schedules, for Procedures Only. Another alternative might be to implement a fee schedule for procedures, while delaying implementation of a fee schedule for visits and consultations until better definitions for those services have been developed. In the meantime, rates for visits and consultations could be based on the CPR system.

This option would have very limited effects, since physicians' receipts for visits and consultations--a substantial component of practice revenues for most physicians--would be unchanged. All generalists would gain a little (1.0 percent to 1.6 percent in allowed amounts, for example) from higher rates for the procedures they perform. Gains for nonsurgical specialists would be higher than for generalists. Surgical specialists would experience a drop in revenues, on average. Overall, about 6 percent of practices would lose 10 percent or more in allowed amounts, with surgical specialties affected the most. Eleven percent of practices would gain 10 percent or more in allowed amounts, while more than 82 percent of practices would experience either gains or losses that were less than 10 percent of allowed amounts. The effects on revenues from Medicare patients and from all patients would be much smaller, on average, than the effects on allowed amounts (see Table B-8).

LOCATION DIFFERENTIALS

Once a relative value scale (with or without specialty differentials) had been established, location-specific multipliers could be designed to adjust the level of payment rates to reflect local differences in customary charge levels or in physicians' costs--just as DRG rates are adjusted for local wage costs under the prospective payment system, using the PPS wage index.